



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

St David's Rehabilitation Oak Hospital

Respondent Name

Standard Fire Insurance Co

MFDR Tracking Number

M4-13-2617-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

June 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule §134.404. Rules 134.403 and 134.404 are for outpatient and inpatient medical services, which are provided in an acute care hospital. TDI, DWC does not have a fee guideline for inpatient rehabilitation facilities. In absence of a negotiated contract, those service would be reimbursed at "fair & reasonable" in accordance with Rule 134.1. Therefore, our client's claim would be reimbursed at "fair & reasonable" at 100% of total billed charges. In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the Hospital Facility Fee Guideline for inpatient services. "

Amount in Dispute: \$23,863.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider has submitted additional supporting documentation to support their allegation that their full billed charges represent "fair and reasonable" reimbursement. The Carrier has reviewed the documentation submitted by the Provider. While the Carrier disagrees that the documentation substantiates that full billed charges are "fair and reasonable", the Carrier agrees that the documentation warrants additional reimbursement. Based on the documentation, the Carrier has further adjusted the conversion factor utilized in the original reimbursement determination. The Carrier has calculated "fair and reasonable" reimbursement based on the Medicare model as dictated by Texas Labor Code Sect. 413.011(a), using Division selected conversion factors for similar types of services, and concluded that "fair and reasonable" reimbursement for the services at issue is substantiated at \$14,583.52. Supplemental reimbursement for the difference between this amount and the original reimbursement is being issued. The Carrier has a substantiated methodology for calculating reimbursement, based on the structure dictated by the Legislature and adopted by the Division in APA-complain rule-making. The Provider has submitted no contrary or conflicting documentation or methodology to support their allegations of entitlement to full billed charges. As the Carrier has reimbursed the Provider consistently with the methodology outlined, the Carrier contends this appropriately reflects "fair and reasonable" reimbursement as required by Rule 143.1. The Carrier contends the Provider is not entitled to additional reimbursement. "

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 11 – 21, 2012	Inpatient Rehabilitation Hospital Services	\$23,863.42	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404, effective March 1, 2008, provides the fee guideline for inpatient hospital services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment

Findings

1. This dispute relates to inpatient rehabilitation services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor asserts, "The claim presented by the Provider was billed in the same manner and at the same rates that it would bill any health plan, insurer, or other medical bill payor. There is no evidence provided by the carrier that the disputed charges were not billed at the hospital's usual and customary rate."
 - The requestor did not submit documentation to support that 65% of the charges constitutes fair and reasonable payment.
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

A discount from billed charges was another method of reimbursement which was considered. Again,

this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	_____ April , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.